



Department of Vermont Health Access
NOB 1 South, 280 State Drive
Waterbury, Vermont 05671-1010

~Antipsychotic Medications (Pediatric) (Age <18 Years Old)~ Prior Authorization Request Form

In order for members to receive Medicaid coverage for medications that require prior authorization, the prescriber must complete and fax this form to Change Healthcare. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information. For questions, please contact the Change Healthcare helpdesk at 1-844-679-5363.

Submit request via Fax: 1-844-679-5366

Prescribing physician:

Name: _____

Physician NPI: _____

Specialty: _____

Phone#: _____

Fax#: _____

Address: _____

Contact Person at Office: _____

Beneficiary:

Name: _____

Medicaid ID#: _____

Date of Birth: _____ Sex: _____

Pharmacy Name: _____

Pharmacy NPI: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

1. The following target symptoms or diagnoses for which the requested medication is being prescribed (Please check all that apply):

Target Symptom	Diagnosis
<input type="checkbox"/> Grandiosity/euphoria/mania	<input type="checkbox"/> Autism with Aggression and/or Irritability <input type="checkbox"/> Bipolar Disorder
<input type="checkbox"/> Obsessions/compulsions	<input type="checkbox"/> Intellectual Disability with Aggression and/or Irritability
<input type="checkbox"/> Psychotic symptoms	<input type="checkbox"/> Obsessive Compulsive Disorder <input type="checkbox"/> Tourette's Syndrome
<input type="checkbox"/> Tics (motor or vocal)	<input type="checkbox"/> Schizophrenia/Schizoaffective Disorder
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Disruptive Mood Dysregulation Disorder
	<input type="checkbox"/> Major Depressive Disorder with Psychotic Features
	<input type="checkbox"/> Other: _____

2. Drug Requested (check below): Strength, Dosage Form, Route & Frequency: _____

Preferred After Clinical Criteria Are Met	Non-Preferred
<input type="checkbox"/> ARIPIPRAZOLE (compare to Abilify®)	<input type="checkbox"/> Abilify® (aripiprazole) <input type="checkbox"/> Quetiapine ER (compare to Seroquel XR®)
<input type="checkbox"/> RISPERIDONE (compare to Risperdal®)	<input type="checkbox"/> Asenapine (compare to Saphris®) <input type="checkbox"/> Risperdal® (risperidone)
<input type="checkbox"/> QUETIAPINE (compare to Seroquel®)	<input type="checkbox"/> Clozaril® (clozapine) <input type="checkbox"/> Saphris® (asenapine)
<input type="checkbox"/> ZIPRASIDONE (compare to Geodon®)	<input type="checkbox"/> Clozapine® (compare to Clozaril®) <input type="checkbox"/> Seroquel® (quetiapine)
<input type="checkbox"/> OLANZAPINE (compare to Zyprexa®)	<input type="checkbox"/> Geodon® (ziprasidone) <input type="checkbox"/> Seroquel XR® (quetiapine XR)
	<input type="checkbox"/> Invega® (paliperidone) <input type="checkbox"/> Zyprexa® (olanzapine)
	<input type="checkbox"/> Latuda® (lurasidone) <input type="checkbox"/> Other: _____
	<input type="checkbox"/> Paliperidone (compare to Invega®)

3. Please list preferred medications previously tried and failed for this condition:

Name of medication

Reason for failure

Date

4. Has the patient received a comprehensive evaluation including non-pharmacological therapies (behavioral, cognitive, family based)? _____

5. Does the patient have any preexisting medical conditions such as obesity or diabetes? _____

6. Have baseline labs including CBC, fasting glucose or HbA1C, and lipid profile been completed? _____

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in your medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.

Prescriber Signature: _____ Date of request: _____

